UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Arkansas
Insurance Fraud Investigation Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

For State Use Only
Case No. Status FYI

Reporting Person:	Insurance Company:	NAIC#
Mailing address:	Phone number: ( ) Fax number: ( ) E-mail address:	
Detailed synopsis. Attach additional pages, if necessary.		

Date of Loss / Injury: Address of Loss / Injury: (City) (State) (Zip)	Dates of Service: to Description of Service:
Claim #	Policy #

Reserve Amount $	Amount Paid $	Date Paid	Procedure Code #'s: ☐ CPT ☐ CDT	Insurance Type ☐ PC ☐ WC ☐ HC ☐ Auto ☐ Life ☐ Disability
Loss Amount $	Settlement Amt. $	Date Paid	Civil Litigation Pending: ☐ Yes ☐ No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN☐ EIN☐ Number:	Sex: M ☐ F ☐

City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.

Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:

Employer:	Address & Phone #:	Occupation:

Additional Party Involved ☐ **See Additional Party Involved/AKA Information** AKA Information: ☐	Comments:

Case Details (check all that apply)

SIU Investigation Completed ☐ Yes ☐ No Date Completed:

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No

☐ Statements (Witness / Insured / Subject)	☐ EUO / Deposition	☐ Law Enforcement / Other Agency Reports
☐ Sworn ☐ Recorded	☐ Copies of Receipts	☐ Claim History Extracts
☐ Proof of Loss	☐ Expert Reports	☐ IME Reports
☐ Continuance of Disability Forms	☐ Videos / Photos	☐ Investigative Reports
☐ Medical Records	☐ Claim Information	☐ External Database results
☐ Other	☐ Other	☐ Other

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: _____ Contact Person: _____
(Address) _____ (City) _____ (State) _____ (Zip) _____
Telephone (____) _____ Fax (____) _____ Case/Claim No._____

Suspected Fraud Types (check all that apply)

- ☐ Arson
  - ☐ home ☐ vehicle ☐ business
- ☐ Fictitious loss ☐ damages ☐
- ☐ Fictitious theft
  - ☐ vehicle ☐ property
- ☐ Inflated inventory
- ☐ Inflated loss ☐ damages ☐
- ☐ Inflated theft
  - ☐ vehicle ☐ property
- ☐ Double-dipping
- ☐ Exaggerated injuries
- ☐ Injuries not related to work
- ☐ Malingerers
- ☐ Misappropriated vehicle salvage
- ☐ Premium avoidance
- ☐ Prior injuries
- ☐ Slip and fall
- ☐ Staged injury / accident at work
- ☐ Staged collisions
- ☐ Paper accidents
- ☐ Other _____
- ☐ Agent fraud
- ☐ Application fraud
- ☐ Billing for services/products not provided
- ☐ Failure to disclose multiple insurance companies
- ☐ False claims
- ☐ Illegal solicitation (cappers)
- ☐ Issued fraudulent insurance policies, certificates, binders, ID cards
- ☐ Misrepresentation of services / products provided
- ☐ Kickbacks/bribery
- ☐ Money laundering
- ☐ Multiple claims
- ☐ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
- ☐ Questioned documents
  - ☐ altered ☐ forged ☐ falsified ☐ duplicated
- ☐ Received compensation for referral to health care provider or attorney
- ☐ Ring / organized activity type
- ☐ Duplicate billing for same service
- ☐ Forged prescriptions
- ☐ Fraudulent death claims
- ☐ Over-utilization of services
- ☐ Prescription abuse / doctor shopping
- ☐ Prescriptions issued for non-medical purposes
- ☐ Unbundling
- ☐ Upcoding
- ☐ Misrepresented non-covered services as covered
- ☐ Changing dates of service, CPT/CDT/diagnostic codes
- ☐ Charges inconsistent with services provided
- ☐ Products billed are inconsistent with the products
- ☐ Using unqualified/unlicensed persons to perform billable services
- ☐ Other _____

Subject / Additional Party Types

CL	Claimant
IN	Insured
WT	Witness
LC	Lawyer for Claimant
LI	Lawyer for Insured
INS	Insurer
SI	Self-Insured
IY	Insurance Company Employee
IB	Agent/Broker
IS	Adjuster
IR	Appraiser
BS	Body Shop
SY	Salvage Yard Owner / Employee
TY	Tow Yard Owner / Employee
MD	Medical Doctor
DO	Doctor of Osteopathic Medicine
DEN	Dentist
PH	Pharmacist
CHI	Chiropractor
NP	Nurse Practitioner
LPN	Licensed Practical Nurse
PT	Physical Therapist
PA	Physician's Assistant
OP	Optometrist
PO	Podiatrist
RD	Radiologist
MT	Massage Therapist
AMB	Ambulance Service Employee
DME	DME Supplier
HHA	Home Health Agency
MR	Laboratory
MH	Medical Clinic/Hospital
MZ	Office Administrator
BS	Billing Services
TPA	Third Party Administrator
FP	False Provider
UP	Unlicensed Provider
MN	Other Medical Personnel
MS	Medical Specialist
_____	
DS	Dental Specialist
_____	
NS	Nurse Specialist
_____	
OT	Other
_____	

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):		Address Type: ☐Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN☐ EIN☐ Number:		Sex: M ☐ F ☐
City:	State:	Zip:	County:	Telephone No.: ( )		Phone Type: ☐ home☐ cell☐ bus.
Driver's License #:	State:	VIN:		Telephone No.: ( )		Phone Type: ☐ home☐ cell☐ bus.
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:			Occupation:		
Involvement in referral:						

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐			
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Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
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Driver's License #:	State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.		
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:	Occupation:				
Involvement in referral:						

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City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.	
Driver's License #:	State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.		
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:	Occupation:				
Involvement in referral:						

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City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.	
Driver's License #:	State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.		
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:	Occupation:				
Involvement in referral:						

The Uniform Suspected insurance Fraud Reporting Form was adopted by the NAIC Anti-Fraud Task Force on March 11, 2003. This form will replace the prior form adopted by the Anti-Fraud Task Force. The purpose of the form is to provide a standardized reporting platform for use by the insurance industry. It is the hope of the task force that by changing the existing format, insurance fraud data will not only be easier to report but also easier to track.

These directions will provide a general explanation of the information that should be contained in each data field of the form. You will find that some data fields could have multiple entries, such as phone number, driver's license number, address, etc. The easiest way for the insurance fraud division to track the information is to complete the form as it relates to the person/business mentioned in the Subject section. If the subject has an alias with different dates of birth, etc., please complete this information in the Additional Parties section of the form so investigators can differentiate between which personal data is connected to each subject name.

Reporting Person and Insurance Company Information	
State of _____	Fill in the name of the state that the referral should be sent to. If the referral should be sent to more than one state because of jurisdiction, please send a separate referral to each affected state and complete the "Other Agency" portion of the referral form to alert the state fraud agencies so that they may coordinate their investigations.
Reporting Person	Name of the person who is completing the referral and can be contacted for additional information if necessary.
Insurance Company	Use the name of the insurance company that is the victim of the suspected fraud. Avoid using a "group" name.
NAIC #	The insurance company's 5-digit number issued by the National Association of

	Insurance Commissioners.
Mailing address	The mailing address of the person sending the referral
Phone number	Telephone number of the person sending the referral
Fax number	Fax number of the person sending the referral
E-mail address	E-mail address of the person sending the referral
Loss and Suspected Fraud Information	
Detailed Synopsis	A report of the suspected insurance fraud. Please provide enough information to clearly indicate what the fraudulent activity is and any persons involved. Attach additional pages, if necessary. If you mention a person in this section, you should also provide more information about that person in either the "Subject Information" area or the "Additional Party Involved" area.
Date of Loss / Injury	Enter the date that the loss, claim, or injury occurred
Address of Loss	Address where the loss, claim, or injury occurred
Dates of Service	The date(s) of the health-related services that were provided to the insured or patient that are in question. Complete this section if the health-related services are in question.
Description of Service	Description of medical or dental service or procedure
Claim #	Claim number of the suspected fraudulent claim. If there are additional claim numbers that relate to the same investigation, please complete an additional referral form to capture the information as it relates to each individual claim.
Policy #	Policy number related to suspected fraud. If there is more than one policy number that relates to the investigation, please complete an additional referral form to capture the information as it relates to each individual policy.
Reserve Amount $	Dollar amount held in reserve related to the fraud referral
Amount Paid $	Dollar amount currently paid related to the fraud referral

Date Paid	Date that the payment was made	
Loss Amount $	Dollar amount of the loss related to the fraud referral	
Settlement Amount $	Dollar amount of any settlement paid related to the fraud referral. If applicable, complete parties to all settlements in the "Additional Parties" section.	
Date Paid	Date that the settlement was paid	
Procedure Code #'s: ☐ CPT ☐ CDT	Use the five- digit CPT Codes or the CDT codes for the mental or dental services related to the referral.	
Insurance Type	Check off the type of insurance policy or policies that are related to the suspected fraud.	
	PC	property & casualty (includes homeowners, farm, general liability, commercial property, commercial liability, inland marine)
	WC	workers' compensation
	HC	health care (includes health, HMO's, dental, vision)
	Auto	personal auto, commercial auto
	Life	life insurance (including credit life)
	Disability	disability insurance (including credit disability)
Civil Litigation Pending ☐ Yes ☐ No	If "Yes is checked, please indicate any pertinent dates related to the litigation., such as a trial date.	
Subject Information		
Type	Indicate the role the subject had in this referral. "Type" codes are on page 2 of the referral form. If you do not find a "type" that is appropriate, use OT for "other" and fill in a description of the role in the space provided below OT.	
Name (Last/Business), (First), (Middle)	The subject's name, or the subject business name, if the subject is a business name, and the subject is unknown.	
Date of Birth	Date of birth of the subject. You may list multiple dates of birth if the dates of birth are used by the subject's name used in the referral. If the subject uses an alias, match the aliases with the dates of birth	

	used with the alias.
Age	Age of the subject
SSN	Social Security Number of the subject
Street Address (Include PO Box and apartments #'s), City, State, Zip, County	Address of the subject. You may list multiple addresses if the subject uses multiple addresses using the subject's name.
Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Indicate if the subject's address is a residence, business, mail drop, or other. type
Fed. TIN☐ EIN☐ Number:	Subject's Federal Tax Identification Number or Employer Identification Number
Sex: M ☐ F ☐	If unknown, do not complete the box.
Telephone No.	The subject's telephone number. There are boxes to enter two phone numbers.
Phone Type ☐ home ☐ cell ☐ bus.	Check off the type of phone number, if known.
Driver's License #	Subject's driver's license number.
State	State that the driver's license was issued in
VIN	The Vehicle Identification Number of the vehicle involved in the referral
Vehicle Year	The year that the vehicle was manufactured
Make	The vehicle manufacturer or brand
Model	The specific type or style of vehicle
License Plate #	The license plate number of the subject's vehicle.
Reported Injuries	A general overview of the subject's injuries
Employer	The name of the subject's employer
Address & Phone #	The address and phone number of the subject's employer
Occupation	The subject's job title and/or profession
Additional Party Involved ☐ AKA Information ☐	If other persons are involved with this referral such as a witness, co-conspirator, etc., please complete a section about them on the "Additional Parties" section. Check off the box if the Subject is known by a different name. Please complete a section in the "Additional Parties" area as well.
Comments	Any information that is relevant to the case, not covered on the form.
Case Details (check all that apply)	
SIU Investigation	

Completed ☐ Yes ☐ No	
Date Completed	
Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No	
☐ Statements (Witness / Insured / Subject) ☐ Sworn ☐ Recorded	
☐ Proof of Loss	
☐ Continuance of Disability Forms	
☐ Medical Records	
☐ Other	
☐ EUO / Deposition	
☐ Copies of Receipts	
☐ Expert Reports	
☐ Videos / Photos	
☐ Claim Information	
☐ Other	
☐ Law Enforcement / Other Agency Reports	
☐ Claim History Extract	
☐ IME Reports	
☐ Investigative Reports	
☐ External Database results	
☐ Other	

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type	**If you have contacted another agency regarding this referral, check off the type of agency.**
☐ **Other State Fraud Bureau**	
☐ **Law Enforcement**	
☐ **Other Insurance Company**	
☐ **Regulatory Agency**	
☐ **Other**	
Agency	**Name of the agency you contacted**
Contact Person	**The person who received or is investigating**

	your referral
Address/City/State/ Zip	
Telephone	
Fax	
Case/Claim No.	The agency's case number or claim number
Suspected Fraud Types	
Suspected Fraud Types	Check all boxes that apply to your referral. The first column relates mostly to Property/Casualty referrals. The second column relates mostly to Fraud Types that could be found in any lie of insurance. The last column refers mostly to Health Care fraud referrals.
Subject / Additional Party Types	
Subject/Additional Party Types	Use the abbreviations to indicate which role that the Subject and/or Additional Parties played in the investigation. You may use more than one type per person.
Grey Box at the end of Referral Form	Additional information that the reporting state would like to inform the sender about. Each grey box will be specific to the state that will be receiving the referral.
Additional Party Involved / AKA Information	
Please use the directions in the Subject Information area to help you complete the Additional Parties section. This section was designed to assist investigators with identifying personal information that belongs to all parties of an investigation or the personal information associated with each alias used by a subject.	